FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-PEORIA REGION

REPORT 17-090-9021
UnityPoint Health – Methodist

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at UnityPoint-Methodist in Peoria. Claims were made of an inappropriate admission, unnecessary use of forced medication, inadequate treatment by staff and an inadequate explanation of the consent process.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).

Methodist Hospital's emergency department treats nearly fifty-five thousand people per year, about five thousand of whom are mental health patients, seen primarily within a special behavioral health section where they await disposition. The hospital also has a sixty-seven-bed inpatient unit. The HRA visited the facility where representatives including those involved in this patient's care were interviewed. Her medical record was reviewed with proper authorization.

COMPLAINT SUMMARY

It was alleged that a nurse in the emergency department advised the patient that she would be able to go home sooner if she signed a voluntary admission application. On the unit, she was reportedly given two forced injections, neither of which were needed. Staff refused to reveal their last names when the patient asked for them and her physician lied in court saying she had kicked someone when actually she brushed against the person's foot while doing yoga. It was also said that the hospital shared confidential health information without explaining that it would be used against her in court. She would have otherwise not agreed to sign a release.

FINDINGS

Inappropriate admission

According to the record, the patient arrived at Methodist involuntarily by ambulance just after 6:00 a.m. A member of the emergency services team that transported her asserted on a petition that the patient had been uncooperative and aggressive with them and the police, that she behaved strangely and that she had a history of such behavior and instability when off her medications. She signed a voluntary admission application at 9:37 a.m. while still in the behavioral health section of the emergency department, which declared that she had been informed of her rights as a voluntary admittee. A mental health associate signed the application as well, stating the patient had been examined for capacity to consent to the admission and certifying her understanding that she could be discharged within five business days from request or be taken to court. There were no entries from the associate or the clinician who examined the patient related to discussions with her on the various admission options or concerns. The patient ended up requesting discharge a few hours later, and a petition for her commitment was filed within two days.

The HRA spoke with the associate who signed the voluntary application and he recalled having no struggles with the patient on admission nor hearing any questions from her about the admission and discharge process. He explained how the clinician typically goes over that information, capacity, etc., in the exam room and then translates everything to him for the paperwork. At no time did he say she would be discharged sooner as a voluntary and he would tell her only the doctor knows that if she asked.

CONCLUSION

Methodist's behavioral health admissions policy simply states that anyone sixteen and older can be admitted voluntarily if deemed clinically suitable and then sets forth various conditions and needs for placement on the appropriate section of the inpatient unit.

The Mental Health Code allows voluntary admissions if the patient is suitable and has the capacity to consent, meaning he understands he is being admitted to a mental health facility and that discharge can be requested in writing and is not automatic. He must be discharged at the earliest appropriate time, not to exceed five days, excluding weekends and holidays unless a petition and two certificates are filed in court. The voluntary form must include this information in detail. (405 ILCS 5/3-400 and 401).

The question is whether the patient was misled about her choice for voluntary admission. Although something about a quicker discharge could have been said in the privacy of an exam room, there is no factual evidence of it from the record or in the associate's account of the patient's visit and the patient signed an application form that expressed her discharge rights in detail. She exercised her right to request discharge immediately and involuntary proceedings were initiated, all in line with her due process rights under the Code. A violation is unsubstantiated.

SUGGESTION

The voluntary application in this record was incomplete without a required statement of why the patient was clinically unsuitable for informal admission. Review the Statute with all employees, clinicians and designates who accept and sign voluntary applications. (405 ILCS 5/3-300c).

Unnecessary forced medication

The record revealed two related injections during the patient's stay, November 9 and 14, 2016.

Documentation for the first injection described how the patient was doing handstands and somersaults in the hallway, saying she was doing yoga. She refused to do that in her room as requested and then accidentally kicked another patient as she carried on. She began to run around the unit and refused medication when it was offered. She "talked over" staff and hugged another patient and would not let go. She was considered a safety risk, given an injection and escorted to the seclusion room where she was put into restraints instead due to safety, according to the note. A restraint/seclusion observation sheet stated that the patient was "loud, angry, not happy to be here, mood liable, crying, laughing, hugging peers, hard to redirect, flipping, skipping in the hallway, kicking peers. Escorted to seclusion…kicking staff, loud, yelling, held for [injection]." The corresponding restriction notice stated that medication and restraints were used for agitation, dangerous behavior and refusing to redirect. The form did not indicate whether the patient's preference for emergency intervention was used or considered or whether she wanted anyone notified of the restriction.

We asked the nurse involved in this incident for further explanation of his notes, how the patient presented the need to prevent serious and imminent physical harm. He said the patient would not redirect from doing somersaults, hugging and kicking other patients. The nurse manager offered that someone could be injured when you are running around, not redirecting in the presence of other dangerous patients.

In documentation for the second injection, the patient was said to be disrupting other patients as they tried talking to their doctors and that she was yelling at her doctor. She "talked over" the staff as she perseverated about being there against her will and then "threatened staff about how she was going to fight them". She refused medication and said she would calm herself down but carried on with the same behavior after a few minutes; she then requested to be restrained. She walked to the restraint room alone where she was given an injection and restrained for about twenty minutes. The observation record stated that she had been sitting on the floor, refusing medication. The corresponding restriction notice listed refusing to redirect and making threats as reasons for the medication and restraints. Again, there is no indication of whether her preference was used or considered or if she wanted anyone notified of the restriction.

The same nurse was involved here as well, and he was asked to explain how the patient threatened staff. He recalled her saying, "I'm going to fight staff". He could not clarify the

nature of her fight, whether she made some kind of physical posture at the same time. "She just said, 'I'm going to fight staff'". He also said that she was intrusive while patients were trying to talk to their doctors, which meant they had limited time with their doctors when she interrupts them. The nurse said that he did consider the patient's emergency intervention preference, which was seclusion and yoga. The treatment plan did not include the patient's preference, if any.

CONCLUSION

Methodist has no emergency psychotropic-specific medications policy.

Under the Mental Health Code, an adult recipient has the right to refuse medication and shall have an opportunity to refuse medication. If refused, they may only be given to prevent serious and imminent physical harm and no less restrictive alternative is available. (405 ILCS 5/2-107). Notice of any restriction must be provided to the recipient, any guardian and any person or agency designated by the recipient. (405 ILCS 5/2-200b and 201). The facility must advise the recipient of the circumstances under which emergency forced medications, restraint or seclusion may be used and ask the recipient if he has a preference. His preference is to be given due consideration should the need arise. (405 ILCS 5/2-200d). Any stated preferences are to be noted on the recipient's treatment plan. (405 ILCS 5/2-102a). Facility directors shall adopt in writing policies and procedures as necessary to implement the rights in Chapter II. Such policies may amplify or expand and may not limit or restrict those rights. (405 ILCS 5/2-202).

The complaint is that medications were forced on the patient without an appropriate need, and both instances here give some concern. In the first, the patient performed calisthenics on a unit hallway and accidentally kicked another patient. She then ran about the unit and hugged another patient, refused to let go, and was taken into restraints where she received an injection after redirections failed. An observation sheet noted the patient to be "loud, angry, not happy to be here, mood liable, crying, laughing, hugging peers, hard to redirect, flipping, skipping in the hallway, kicking peers. Escorted to seclusion…kicking staff, loud, yelling, held for [injection]". Except for the physical contact, these words describe common symptoms of mental illness and do not reach the need to prevent serious and imminent physical harm. On the other hand, staff said that the accidental kicking and the hugging, each happening once by the way but portrayed as chronic in the record, could present harm when involving other dangerous patients. The debate is whether, "could," means imminent, but since physical space was compromised the HRA defers to the staff in this case who believed they kept the milieu free from serious and imminent physical harm. A violation is unsubstantiated. In the second, the patient was described as disruptive, intrusive, talking over staff and patients. The nurse said that she was so intrusive that other patients' time with their doctors was limited, none of which even remotely approaches the need to prevent serious and imminent physical harm. He also wrote in his notes that she "talked over" the staff as she perseverated about being there against her will and then "threatened staff about how she was going to fight them". He was unable to explain her intentions about fighting them and recalled no actual posture or attempt of a physical advance. It was then documented that she calmed down herself for a few minutes and then resumed her intrusive behavior. She requested to be restrained and walked on her own to the restraint room,

which means any "emergency" was over when she calmed down, and no new situation emerged when she walked on her own to the restraint room where she was injected. Furthermore, the fact that she was then restrained because she requested to be is unimaginable. A violation is substantiated.

Although the nurse said that seclusion was the patient's emergency intervention preference it was not noted on her treatment plan, and when her rights were restricted there was no documented indication that her right to have any person or agency notified was honored. Violations are substantiated.

RECOMMENDATIONS

Retrain staff on meeting the standard of *serious and imminent physical harm and no less restrictive alternative is available* and providing supportive documentation. (405 ILCS 5/2-107). Assure that this training is included in new employee orientation when relevant to the position.

Revisit Sections 2-200 and 2-102a with all appropriate staff and require all stated emergency preferences to be noted on respective treatment plans.

Methodist uses a restriction form intended for developmental disability programs that does not include references to the patient's emergency preference or choice for notification; IL462-2004D as opposed to M. Ensure that any emergency preference is considered and that all patients whose rights are being restricted are asked if anyone of their choosing is to be notified. (405 ILCS 5/2-102a; 2-200 and 201).

Develop policy for the use of emergency forced medications. (405 ILCS 5/2-202).

SUGGESTION

Conduct annual rights reviews with staff that include rights associated with emergency forced medication.

COMMENT

Accurate documentation is vital to a mental health patient's record because it follows her for life. In this case, the patient kicked one patient and hugged one patient yet the phrase, "kicking and hugging patients" is repeated throughout as though this happened multiple times. Staff should strive for accuracy and be reminded of the power they have when creating records.

Inadequate treatment

This complaint is about the patient wanting full staff names and the kicking incident being wrongly portrayed in her commitment hearing. The nursing and social work staff told us that every time they meet a new patient they introduce themselves and explain their roles, and

they identify themselves when entering patient rooms. They each wear identification badges with first names, as we observed, and they suggested that much of the charting includes their complete names and titles for every entry. The patient could simply make a record request and find all the staff names she wanted. None of the staff we spoke to recalled the patient asking them personally for their names.

Staff are not required to reveal their full names in Illinois per the Medical Patient Rights Act, "A health care facility that provides treatment or care to a patient in this State shall require each employee of or volunteer for the facility, including a student, who examines or treats a patient or resident of the facility to wear an identification badge that readily discloses the first name, licensure status, if any, and staff position of the person examining or treating the patient or resident. This Section does not apply to a facility licensed or certified under the ID/DD Community Care Act, the MC/DD Act, or the Community-Integrated Living Arrangements Licensure and Certification Act." (410 ILCS 50/6).

Challenging a physician's testimony in court is not an HRA issue but one for the patient's attorney during the hearing. We can however review court documents that initiate hearings, which in this case included the petition and certificate, both of which refer to the kicking as accidental. Although the complaint insists that instead it was a mere brush against another's foot, all of the complimenting documentation from nursing and social work consistently refers to kicking.

None of this can be considered inadequate treatment, and rights violations are <u>not substantiated</u>.

<u>SUGGESTION</u>

Court records aside, perhaps Methodist can remind patients of their rights to enter written disputes of any information within their charts. (740 ILCS 110/4).

Inadequate explanation of consents

Here the issue is the patient approving the hospital's communication with her mother but not knowing that it would be used against her. The patient's record contained a release of information between her mother and the hospital, which the patient authorized on admission. She identified by her initials each content to be disclosed including intake data, history, evaluation, medications, treatment plans, progress notes, treatment/discharge summaries and emergency department records, all of which was to be used for case coordination and treatment planning according to the release form. Contact with the mother for related purposes is documented throughout the record during the patient's stay as is evidence of the mother visiting and attending family meetings with the staff. The mother was quite involved per the documentation.

The social worker explained that she has conversations with all patients about the importance of engaging family or others in their treatment, as well as their rights to identify

someone to be involved, and in this case the patient designated her mother. She remembered going over everything on the release with the patient and offering to answer any questions. She believes the patient understood that her total care and treatment would be discussed with the mother, and at no time did she revoke the release. She also recalled the patient's anger following the hearing, where she was not pleased about the information shared in the hearing and that the patient refused to talk with her about it.

CONCLUSION

Pursuant to the Confidentiality Act, "All records and communications shall be confidential and shall not be disclosed except as provided in this Act." (740 ILCS 110/3). Records and communications may be disclosed with written consent, which shall specify the persons to whom disclosure is to be made, the purpose and the nature of the information to be disclosed as well as the right to revoke consent at any time. (740 ILCS 110/4).

An appropriate release of information was completed with the patient's initials at each item she allowed to be disclosed, which included all facets of care and treatment for case coordination. There is no evidence that she was misled or misinformed about the hospital's intentions with the information, and court testimonies are subjects for the patient's attorney. By all documented indications, Methodist handled the release requirements and the information authorized to be disclosed appropriately, and a rights violation is unsubstantiated.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

UnityPoint Health
Methodist | Proctor

221 Northeast Glen Oak Avenue
Peoria, Illinois 61636-0002
(309) 672-5522

November 22, 2017

Illinois Guardianship and Advocacy Commission
Peoria Regional Office
401 Main Street – Suite 620
Peoria, IL 61602

Re: HRA #17-090-9021

Dear Ms. Tucker:

Regarding the substantiated findings for the above case, we have educated staff on the standard of serious and imminent physical harm and the need for emergency preferences to be noted on respective treatment plans. I am enclosing a copy of the slide that we used for educational purposes. There was significant explanation and discussion led by one of our nurse managers and me related to both issues, with the final training session completed earlier this month. Staff has also been reminded to ask individuals if anyone is to be notified of such restrictions. We are currently revising orientation requirements for new employees and this will be included in that orientation process. We are evaluating the need for a policy on emergency medications.

Our culture is one that embraces continuous quality improvement, so we appreciate the opportunity to work with the Commission and value the recommendations.

Sincerely,

Dean Steiner

Dean Steiner, LCPC
Director, Behavioral Health Services

enc